A. Coordination of Benefits

With specific exceptions, such as school-based services and Birth to 3 services, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid pays that portion of the allowable cost remaining after exhausting all other health insurance sources. Refer to Section IX of Part A, the all-provider handbook, for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. Medicare/ Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are called dual-entitlees. Providers must send claims for Medicare-covered services provided to dual-entitlees to Medicare *before* billing Wisconsin Medicaid.

If the service for a dual-entitlee is covered by Medicare, but Medicare denies the claim, indicate a Medicare disclaimer code in element 11 on the HCFA 1500 claim form. Refer to Appendix 1b, element 11 of this handbook for the appropriate Medicare disclaimer code. Although services covered by Medicare do not require prior authorization (PA) from Wisconsin Medicaid, providers are strongly encouraged to obtain PA for dual-entitlees either at the time of initial Medicare claim submission or following a postpayment reconsideration to ensure Medicaid payment if Medicare denies coverage.

Therapy Crossovers Subject to Medicaid Payment Limitations

Payments on certain therapy crossover claims from Medicare for dual-entitlees are subject to Medicaid maximum allowable fees and rates. Refer to Section IX of Part A, the all-provider handbook, for more information.

C. Qualified Medicare Beneficiary-Only Recipients

Qualified Medicare Beneficiary-Only (QMB-only) and Qualified Medicare Beneficiary-Nursing Home (QMB-NH) recipients are only eligible for Medicaid payment of the coinsurance and the dedcuctibles for Medicare-covered services. If services are denied by Medicare, they are *not* covered by Wisconsin Medicaid.

D. Referring Provider

Claims for occupational therapy (OT) services require the referring provider's name, and a UPIN, license, or provider number in elements 17 and 17a of the HCFA 1500 claim form. Refer to Appendix 1b of this handbook for billing instructions.

E. Reimbursement Methodology

Maximum Allowable Fees Under HFS 107.17

Medicaid maximum allowable fees for *Current Procedural Terminology* (CPT) and HCFA Common Procedure Coding System (HCPCS) codes for OT procedures under HFS 107.17 are based on the national standard Medicare relative value units (RVUs).

The resource-based relative value scale (RBRVS) assigns RVUs based in part on the complexity of procedures. The RBRVS takes into account the provider's work for each procedure, practice expenses, and liability insurance. The work component includes the physical and mental intensity used to perform the service, the time taken to perform the service, and the pre- and post-face-to-face work associated with a typical encounter. The work RVUs for services are based on the expectation that the code's definition represents exactly how the service is furnished when billed to Wisconsin Medicaid. Non-face-to-face time is included in the reimbursement for the face-to-face service.

E. Reimbursement Methodology (continued)

For Wisconsin Medicaid's reimbursement methodology for OTs employed by hospitals and home health agencies, see the provider handbooks for these provider types.

F. Treatment Units

Conversion of Therapy Treatment Time to Medicaid Treatment Units for Billing Purposes

The unit of service is defined by the Medicaid CPT procedure code description. When the description includes the statement "each 15 minutes," then one unit of service is 15 minutes. Part of a unit may be billed by using a number with a decimal point. Refer to Appendix 5 of this handbook for the conversion chart.

Bill Face-to-Face Treatment Time Only

Bill only the face-to-face treatment time actually provided. For example, if the procedure code description references 15 minutes of direct treatment, the provider must have furnished 15 minutes of direct, face-to-face treatment to the individual recipient to bill one unit of service.

G. Daily Service Limitations

Ninety-Minute Daily Coverage Limitations

As described in Section II E, Wisconsin Medicaid does not cover OT services beyond 90 minutes per day unless coverage of additional medically necessary treatment is requested and approved through the claims adjustment process. This limit is based on the determination that OT services in excess of 90 minutes per day generally exceed the medically necessary, reasonable, and appropriate duration of OT services.

If, under extraordinary circumstances, OT treatment is necessary beyond the limitation of 90 minutes per day, providers may request coverage of additional treatment time by submitting an adjustment request form. After the claim is submitted and paid, the non-reimbursed time must be documented as exceeding the 90-minute limitation on the adjustment request form and submitted separately to the Medicaid fiscal agent, EDS, for payment. Refer to Section X and Appendices 27 and 27a of Part A, the all-provider handbook, for information on submitting an adjustment request.

Daily Unit of Service Limitation

Wisconsin Medicaid covers some procedure codes only a limited number of times a day. Refer to "Daily Unit of Service Limit" in Appendix 4 of this handbook for specific limits.

H. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a private-pay patient. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

Do not reduce the billed amount by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the Medicaid-allowed payment.

I. Diagnosis Codes

All diagnoses must be from *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

Order the complete ICD-9-CM code book by writing to the address in Appendix 3 of Part A, the all-provider handbook.

Providers should note the following diagnosis code restrictions:

- Do not use codes with an "E" prefix as the primary or sole diagnosis on the HCFA 1500 claim form.
- Codes with an "M" prefix are not acceptable on the HCFA 1500 claim form.

J. Procedure Codes

Occupational Therapy Procedure Codes

Independent OTs, therapy groups, and rehabilitation agencies must use the CPT procedure codes appropriate to the date of service to bill OT services. See Appendix 4 or the appropriate *Wisconsin Medicaid Update* for the date of service for allowable procedure codes. All HCFA 1500 claim forms require HCPCS codes. Claims or adjustments received without the appropriate codes are denied.

Billing for Services Provided Off the Licensed Hospital Location

Wisconsin Medicaid requires that services provided off the licensed hospital location be billed using appropriate CPT procedure codes on the HCFA 1500 claim form. Refer to Appendix 4 for a list of the OT procedure codes.

Billing for Services Provided at the Licensed Hospital Location

Refer to Part F, the hospital handbook, and appropriate *Wisconsin Medicaid Updates* for hospital services, when billing for services provided at the licensed hospital location.

Billing Evaluation Services in Facilities for the Developmentally Disabled

Evaluation services in facilities for the developmentally disabled are billed using allowable CPT evaluation procedure codes.

Billing for Birth to 3 Services

Federal regulations require that Individuals With Disabilities Act (IDEA) funds are the payer of last resort after all other private and public funds, including Medicaid. This means that for children in the Birth to 3 program, Wisconsin Medicaid providers bill Wisconsin Medicaid before billing the county Birth to 3 program for services included in the child's Individual Family Services Plan.

Contact the child's county Birth to 3 program for billing information where the child's parents deny permission to bill the child's health insurance first.

K. Modifiers

How to Bill Using a Modifier on the HCFA 1500 Claim Form

OTs, rehabilitation agencies, and therapy groups must add a modifier when billing for all OT services.

Modifiers allow OTs and Wisconsin Medicaid to distinguish between physical therapy (PT) and OT services with identical procedure codes. The modifier for OT codes is "OT."

Paper Claim Submission

Enter the "OT" modifier in element 24d on the HCFA 1500 claim form, or Wisconsin Medicaid will deny the claim.

Paperless Claim Submission

Enter the "OT" modifier immediately after the procedure code in field "M1," or Wisconsin Medicaid will deny the claim.

For example, an OT bills procedure code 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility). The OT enters the "OT" modifier in element 24d on the HCFA 1500 claim form.

L. Claim Submission

Paper Claim Submission

The HCFA 1500 claim form is the only acceptable form for paper claims. Claims for OT services submitted on any other paper form are denied. A sample HCFA 1500 claim form and completion instructions are in Appendices 1, 1a, and 1b of this handbook.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the Medicaid fiscal agent, EDS. Refer to Appendix 17 of this handbook for a blank HCFA 1500 claim form. Claim forms are available from many suppliers. One supplier is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Mail completed claims submitted for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Paperless Claim Submission

As an alternative to submission of paper claims, the Medicaid fiscal agent, EDS, may process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. All claims that providers submit are subject to the same Medicaid legal requirements. Providers submitting electronically usually reduce their claim submission errors.

L. Claim Submission (continued)

Refer to Appendix 15 for the Wisconsin Medicaid Paperless Claim Request Form. For more information on paperless claim submission, contact:

EMC Department
EDS
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Claims Submission Deadline

Wisconsin Medicaid must receive all claims for services rendered to eligible recipients within 365 days from the date of the service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

To ensure that your claim is not denied, complete the claim form using:

- The *same* PA number that is on the Prior Authorization Request Form (PA/RF).
- The *same* modifier for the same procedure code that is on the PA/RF.

M. Follow-up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Refer to Appendix 16 for a list of EOB codes (denial codes), how to avoid claim denials, and a sample Remittance and Status Report with EOB codes. The fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.